but subject to paroxysms of fury resembling those of acute mania. More commonly, however, underlying even the aggressiveness and violence, there is a foundation of fear which often resembles that of delirium tremens, and when with this condition of fear there is associated distinct tremulousness, the likeness to delirium tremens is very pronounced; indeed, Wood believes that delirium tremens should be considered a form or variety of confusional insanity.

Very rarely ought there to be any trouble in recognizing the true nature of confusional insanity. The history of the attack, the knowledge that the outbreak was preceded by an exhausting disease, traumatism or emotion, the failure of bodily nutrition and of general nerve force, the lack of dominant emotional excitement, the stupor, the peculiar mental confusion, the kaleidoscopic character of the hallucinations, make diagnosis easy. The propiosis is favorable. Krafft-Ebing gets 70% of recoveries, and in Wood's cases even when the mental confusion has amounted to complete and absolute imbecility, complete recovery has almost invariably occurred, provided there have been no preëxisting organic bodily lesions, such as unsound kidneys, or degenerated arteries. Death may, however, occur in complicated cases. If the mental recovery be not complete, the result is lack of mental power, but never a so-called reasoning insanity, never a state resembling that of paranoia. Wood cites five cases illustrating his conception of confusional insanity: I., after childbirth; II., after removal of the breast for cancer; III., after perineorraphy; IV., after typhoid; V., after loss of sleep from nursing, combined with anxiety. All the patients recovered.

Cases of Post-Febrile Insanity. WILLIAM OSLER, M. D. John Hopkins' Hospital Reports, 1890, II, 46.

This article is written to give illustrative cases of Wood's Confusional Insanity, where there is one fundamental brain condition, viz:—impaired nutrition with consequent exhaustion of the nerve centres. Osler refers to the articles by Shepard (Am. J. Med. Sciences, Dec., 1888), and T. Gaillard Thomas (Medical News, 1889), and reports five cases:

I. Pneumonia. Slow convalescence with development of hallucinations and delusions.

II. Typhoid fever; severe attack with much delirium. Mania during convalescence. Gradual recovery after four months.

III. Typhoid fever of moderate severity. Development of delusions during convalescence. Recovery after six weeks.

IV. Typhoid fever, mild attack. Gradual development of delusions. Slow, halting speech. Recovery.

V. Typhoid fever, severe attack. During convalescence development of delusions. Persistence of mental symptoms for ten weeks. Recovery.

Prognosis usually good. Of the seven cases seen by Osler five after typhoid and two after pneumonia, six recovered and the seventh seemed likely to recover. Patients should therefore be cared for at home if possible. Seclusion, incessant watchfulness, absolute rest in bed, with massage and careful feeding are indicated. In the cases where the temperature is mentioned this had fallen to normal before the mental symptoms came on.

Osler does not attempt to add to Wood's description of the mental state of these patients.

Acute Confusional Insanity. CONALLY NORMAN. Dublin Journal of Medical Science, 1890, I, 506.

Norman claims that this form of insanity is not recognized in England. He agrees with Salgó that acute confusion is the most common of all forms of insanity, although Salgó's definition is too wide according to Norman. It would come between the acute mania and acute

primary dementia of Pinel. It is a condition of mental disturbance of comparatively rapid onset, characterized by dream-like engagement of consciousness and a tendency to abundant hallucinations of one or more senses. As the confusion or the hallucinations predominate the case resembles acute dementia or mania (melancholia.) Predominance of confusion corresponds to the delusional stupor of Newington; predominance of hallucinations corresponds to Mendel's hallucinatory mania. Norman finds hallucinations less frequent than other authors, and quotes Meynert as giving up the term acute hallucinatory insanity (Wahnsinn) for confusion. It is acute in onset; in form, acute or peracute, more frequently sub-acute. True chronicity hardly exists, except in uncured cases lapsing into secondary mania. Usually begins with hallucinations. Recovered patients speak of a dreamy obscuration of the mind; this frequently escapes observation. Consciousness profoundly affected; unoriented; confused as to time; varying and disconnected delusions flit through the mind, which are accepted as we accept dreams. Hallucinations may be pleasant or the reverse, following the emotional state of the patient. Emotional state generally indifferent, without pleasure or pain. Emotional condition variable as distinguished from mania or melancholia, sometimes gay, sad, anxious, angry, tender, or all these things together or in most rapid succession. Emotional disturbance is a reactive one, arising from the nature of the hallucinations. Acts as well as feelings are dictated by hallucinations. Episodic reactive states of emotional excitement or motor restlessness are apt to be followed by periods of increased confusion, deepening into stupor, or stuporous conditions intervene directly. Agrees with Krafft-Ebing that acute confusional insanity is essentially a condition of brain exhaustion, and probably due to brain anaemia or malnutrition of cortex. Patient is usually feeble and anaemic, or has recently suffered from some exhausting disease. This is more often than any other the form of psychical disorder associated with diseases not primarily affecting the nervous centres. Puerperal insanity is generally of this form, and the same of the insanity of rheumatism, and the delirium of fevers occasionally passes directly into acute confusion. Prolonged lactation, chronic suppurative affections, diseases of the stomach and of the lungs, especially phthisis, have a strong predisposing, if not exciting influence. Krafft-Ebing describes it as arising in prisoners. Norman has found it associated with nostolgia. Also occurs in cases of sexual excess or irregularity, generally with hallucinations. One case followed mental shock; and it is to be noted that the most common form that insanity takes when it follows sudden shock is the kindred one of acute dementia. Norman considers the well marked form of insanity following drink as acute confusional insanity, which is usually described as something between *delirium tremens* and acute mania. There is loss of orientation, dream-like impairment of consciousness, and numerous hallucinations. Dreamy confusion is more common in women. James Ross has described a confusion characteristic of dementia accompanying alcoholic neuritis. Wiglesworth confirmed Ross's observation, and in 1887 Korsakoff described in connection with alcoholic neuritis a "form of confusion with extremely characteristic mistakes in relation to space, time and situation." The onset is often acute. The insanity which comes "out of sleep" is always of this type. This brings it into line with that state occasionally present in the sane and especially in those of neurotic tendency and in epileptics, called by Germans *Schlafkrankheit*. Duration may be short, lasting only a few days or a few hours in abortive cases (as in some cases of menstrual disturbance), as Krafft-Ebing points out. Krafft-Ebing puts his recoveries at 70%. Cases which are about to recover occasionally pass into a state resembling acute mania, first observed by Meynert, who thought that the functional hyperaemia accompanying the maniacal

attack brought on a tendency to cure by increasing the circulation of blood through the exhausted brain. A slight degree of stupor more frequently precedes recovery, as in convalescence from acute mania. A mixture of maniacal and stuporous conditions is less favorable, or a tendency towards histrionic and pathetic displays, or the occurrence of pseudo-tetanic or pseudo-cataleptic states. Latter symptoms approximate Catatonia, which indeed is probably to be regarded as a variety of the general affection under consideration. As in all acute insanities death from exhaustion may occur in the early stage, and in debilitated sufferers there is a tendency to succumb to intercurrent affections. The diagnosis lies between acute mania, acute melancholia, acute dementia, and certain forms of paranoia. From mania it is distinguished by absence of exaltation and of increased rapidity of thought. (Norman, with Salgó, would exclude from mania any case with hallucinations). True emotional depression as a primary symptom is absent in acute confusion, distinguishing it from melancholia. It is intimately associated with acute dementia, and it is not always possible to say which form we are dealing with, though the presence of hallucinations and absence of complete stupor in a typical case of complete confusion sufficiently denote the ailment. Distinguished from paranoia by want of systematization of delusions, by existence of confusion, and by sudden mode of origin.

Norman repeats nine cases as follows:

I. Acute confusion, associated with alcoholic excess. Neuritic pains; recovery.
II. Acute hallucinatory confusion, associated with alcoholic excess; epileptiform seizures; recovery. "An extremely typical case of alcoholism in a woman."
III. Acute hallucinatory confusion associated with alcoholic excess.
IV. Confusion in the special form described by Ross and Wigglesworth occurring in a toper. Passage into secondary dementia.
V. Acute hallucinatory confusion resembling paranoia, associated with alcoholic excess. Recovery.
VI. Acute hallucinatory confusion simulating paranoia, following rheumatism and perhaps associated with nostalgia. Recovery.
VII. Hallucinatory confusion associated with phthisis.
VIII. Acute hallucinatory confusion dependent perhaps upon nostalgia. Passage into dementia.
IX. Acute hallucinatory confusion beginning in a dream. Apparent cause, sexual irregularity.

Norman cites Korsakoff's articles and considers that they are both describing the same form of mental disturbance.

Folie post-opératoire. PROF. MAIRET. Le Bulletin Medical, 1889; Aug. 28 and Sept. 1.

Prof. Mairet studies the mode of evolution of insanity following operations rather than the form of the insanity itself. He adds one case to literature, that of a woman of 42 who became insane three days after a laparotomy. Patient was intelligent and vivacious, but without hereditary or degenerative nervous taint. At 22, after childbirth, she suffered from attacks of hysteria with syncope, without absolute loss of consciousness, but with delusional troubles following, and hallucinations of sight and hearing; attacks sometimes lasted minutes, at other times hours; troubles appeared with menses. Intellect unimpaired, and she retained the management of her household. At 39 abdominal trouble appeared, necessitating laparotomy three years later. Three days after the operation began to laugh without motive and to have hallucinations of hearing. Delusions increased and patient admitted to asylum three months and a half after operation. Torpor and intellectual wandering